



Division Guideline #28

Date: Created August 29, 2012

Title: Managing Medicaid Spend Down Amounts

Application: Community Providers

The intent of this document is to establish statewide policies regarding who is responsible for meeting spend down amounts and from what funds spend down is paid. This policy also addresses under what circumstances the provider is reimbursed for spend down from DD funds.

Spend Down

Medicaid spend down must be maintained monthly pursuant to Division Guideline #16. The following guideline applies to situations where spend down dates have been established with the Family Support Division. The cost of spend down should be taken into consideration when determining available funds for room and board costs.

Individual's monthly benefit is used to cover ineligible periods if at all possible. The following are the steps that are to be taken for services rejected for established spend down dates (*Rejection code 178, Payment adjusted because the individual has not met the required spend down requirements*).

1. If DD is representative payee for benefits, the spend down is paid using the individual's benefits and services are resubmitted to MO HealthNet for payment. If funds are not available in the account, the Regional Office may authorize one-time funding from other sources (e.g. SCL, POS).
2. If DD is not the payee, the financially responsible party (i.e. individual, parent, guardian, public administrator) is responsible for paying the provider directly.
3. The Regional Office shall pay the provider the full cost of services provided but not paid by Medicaid Waiver up to two months. If the financially responsible party has recurring issues with meeting monthly spend down and maintaining Medicaid eligibility for 2 months, the provider will be notified by the Regional Office and a meeting will be held to develop solutions to address this issue.

===== DD Business Office Use Only=====

Medicaid Rejection Steps by Rejection Code

Following are the general guidelines to follow for the most common rejection codes experienced in the Medicaid Waivers.

1. Immediately after the remittance advice (835) data is received, designated Regional Office staff obtain the CIMOR Remittance Advice report on Reporting Services.
2. DD General Revenue (GR) must always be the funding of last resort. References to "DMH GR" refer to the "Bill DMH" button on the CIMOR Encounter screens.
3. Rejections by reason code.
 - a. *141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.* This occurs due to the service being billed for a date range such as transportation. DD Waiver services do not need to be billed for a date range. Re-bill the rejected service and change the "From Date" to the same as the "To Date" (preferably the last day of the month or actual date of service). If the Individual's eligibility is incorrect, have the reimbursement officer or support coordinator work with the family support office to correct it.
 - b. *45 - Charges exceed your contracted/ legislated fee arrangement.* This indicates that the rate was billed in excess of the Medicaid maximum rate. No rebilling or adjustments are necessary as Medicaid will pay up to the cap. Do not pay the provider the difference. If the contract rate is above the cap, it must be lowered. The only exception to this is for people enrolled in Self- Directed Services.
 - c. *8 - The procedure code is inconsistent with the provider type/specialty (taxonomy).* This usually indicates a technical issue with how the code is set up in the Medicaid system. Contact DD Central Office or submit a help ticket. Wait to re-bill the service until notification is received verifying the issue has been resolved. Do not pay the provider from GR.
 - d. *178 - Payment adjusted because the individual has not met the required spend down requirements.* Follow steps 1-4 of the Spend Down policy.
 - e. *96 - Non-covered charge(s).* Contact MHD help desk or local Family Support office. This requires some investigation to ensure the appropriateness of the charge.
 - f. *B5 - Payment adjusted because coverage/program guidelines were not met or were exceeded.* Medicaid was billed for more than the maximum allowable units for the specific procedure code. Medicaid rejects the entire amount in this case. The claim is re-billed for the maximum units allowed. The provider may be reimbursed for the difference at the Regional Office discretion through a POS code.
 - g. *18 - Duplicate claim/service.* Billing error usually due to timing issue with voided and re-billed services. Correct as quickly as possible. Do not pay the provider from general revenue.
 - h. *125 - Payment adjusted due to a submission/billing error(s).* This usually results from an invalid code. The procedure code may not be valid for the individual's waiver type or the procedure code is not set up correctly at Medicaid. If the code was not valid for the individual's waiver type, the provider must either be paid from GR or a

code appropriate for the individual's waiver type authorized. The invalid authorization must be terminated and the encounters voided. If a technical issue caused the error, the provider will be reimbursed when the Regional Office re-bills for the service.

- i. *31 - Claim denied as individual cannot be identified as our insured.* Eligibility or issue with individual's DCN. Investigate with Family Support office. Pay using GR only when it has been determined that a Waiver was mistakenly authorized.
- j. *177 - Payment denied because the individual has not met the required eligibility requirements.* This message is due to the individual losing eligibility and/or spend down not being met. The provider payment is held until the individual's eligibility can be restored. This includes but not limited to re-verification, spend down expenditure documentation, and/or spend down premium. Once eligibility is restored, the rejected services are re-billed. Refer to Division Guideline #16 on establishing spend down dates with the Family Support Division (DOSS).

This guideline will be reviewed and updated annually, as needed.